



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

June 22, 2006

Roger Malm, Administrator
Ashley Manor - Beverly Hills, Ashley Manor LLC
861 Beverly Hills Drive
Payette, ID 83661

Dear Mr. Malm:

On June 8, 2006, a complaint investigation survey was conducted at Ashley Manor - Beverly Hills, Ashley Manor LLC. The survey was conducted by Patrick Hendrickson, R.N., and Frutoso Gonzalez, R.N. This report outlines the findings of our investigation.

Complaint #ID00001389

Allegation: The facility did not provide enough supervision to meet the needs of an identified resident, as the resident went out the back door of the facility and was found lying on the concrete patio.

Findings: Based on interview and record review, it was determined that the facility did provide enough supervision to meet the needs of the identified resident. However, the resident did go out the back door of the facility and was found lying on the concrete patio.

Review of the facility's admission and discharge register on June 8, 2006 revealed that the identified resident was transferred to a hospital and discharged from the facility on May 5, 2006. The resident was not available for interview.

Review of the identified resident's closed record on June 8, 2006 revealed that she was admitted to the facility on September 10, 2005 with diagnoses that included Alzheimer's dementia, coronary artery disease, and atrial fibrillation.

The record contained a "Personal History and Assessment," which was the facility's uniform assessment instrument, dated September 8, 2005. The facility assessed the identified resident as needing direction and cueing, but was able to ambulate on her own.

Further review of the record revealed a negotiated service agreement (NSA) dated September 19, 2005, which documented that the facility was to provide stand-by assistance at all times due to the possibility of falls because of unsteadiness.

Review of the identified resident's "Progress Notes" from September 10, 2005 to May 8, 2006 revealed the following entries:

- September 10, 2005 (un-timed): "She has a history of hx fractures, but has been released from physical therapy by physician. She requires close supervision due to her history of falls."
- May 5, 2006 (un- timed): "[The identified resident] had a fall Friday May 5, 2006 at approximately 2 p.m. We had gotten her ready for a doctor's appointment and she was waiting for [her daughter] to get here. [The identified resident] was up walking around and I saw her head for the back door and I heard it open. I asked my assistant to go check on her. It was at that time she yelled for me to go outside. She had found [the identified resident] lying flat on her tummy." The facility documented that 911 was called and the resident was transported to the hospital.

The progress notes contained documented evidence that the identified resident was independent with mobility while at the facility. Further review of the progress notes revealed no document evidence of falls except for the fall that occurred on May 5, 2006.

Review of the facility's accident reports on June 8, 2006 revealed documented evidence that the identified resident had walked outside of the facility to the patio on May 5, 2006. The resident was followed by a caregiver to the patio. The caregiver found the resident lying face down on the patio. The facility documented that 911 was called and the resident was transported to the hospital by emergency medical services. The resident's physician, the facility's nurse, and the resident's family were notified at 2:15 p.m. on May 5, 2006.

The resident's closed record contained an emergency room report dated May 5, 2006 (un-timed) that documented the resident had a syncopal episode on the back patio of the care center on May 5, 2006 and sustained a one inch laceration to her right brow. It further documented that, at that time, the resident was alert and orientated to place, person, and time.

On June 12, 2006 at 9:40 a.m., the administrator stated that on May 5, 2006, caregivers assisted the identified resident to get ready for a doctor's appointment. She said that the resident was waiting for her family. The administrator stated that the resident got up and walked toward the backdoor which lead to the enclosed patio.

The resident was followed by a caregiver to the patio and the resident was found lying on the patio. She said 911 was notified and the resident was transported to the hospital by the emergency medical services.

On June 21, 2006 at 9:10 a.m., the house manger stated that the facility "watched the resident closely" to assure the safety of the identified resident. She stated that caregivers provided stand-by assistance, where a caregiver stayed with the resident while she used the toilet and while in the shower. She said that the resident was always within the line of sight of a caregiver. She stated that the facility would do every-15-minute checks on the resident during the night. The house manager confirmed that the facility assessment was accurate for the functional status of the resident while she was in the facility. She confirmed that the NSA reflected the care the resident received.

Conclusion: Substantiated, but not cited. The identified resident had only one documented fall since she had been admitted to the facility on September 10, 2005. The facility documented that the resident was independent in mobility while she was at the facility. The facility assured that the resident was in line of sight when she was ambulating in the facility. Two caregivers were in the facility when the resident fell. A caregiver quickly followed the resident when she was seen going to the back door. Additionally, they obtained emergency services for the resident and notified the physician, facility nurse, and family.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

A handwritten signature in black ink, appearing to read "Frutoso Gonzalez R.N.", with a stylized flourish at the end.

FRUTOSO GONZALEZ, R.N.
Team Leader
Health Facility Surveyor
Residential Community Care Program

FG/sm

c: Virginia Loper, R.N., Supervisor, Residential Community Care Program